Rhymecare Ltd

Manor Barn Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 29 November 2016 and was unannounced.

Manor Barn Nursing Home provides accommodation for up to 31 older people, some of whom are living with dementia and who need support with their nursing and personal care needs. On the day of our inspection there were 25 people living at the home. The home is a large property, spread over two floors, situated in Fishbourne, Chichester. There is a communal lounge, a dining room and a well maintained garden.

The management team consisted of a registered manager and a deputy manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were asked their consent before being assisted and there were measures in place to ensure that people's relatives had been involved in decisions about people's care needs. However, practice and the lack of records confirmed that there was a lack of understanding in relation to the practical application of mental capacity assessments (MCA) and the deprivation of liberty safeguards (DoLS). Mental capacity assessments that had been completed were not decision specific and deemed a person not to have capacity simply due to the fact that they were living with dementia. Decisions for some people had been made by someone who was legally unable to make those decisions and best interest decisions had not always involved the relevant people. There was a potential lack of DoLS applications made and a DoLS authorisation that had been granted had not been renewed. The lack of understanding and practical implementation of the MCA and DoLS were areas of concern.

People had access to activities on certain days and records showed that people had enjoyed visits from external entertainers. However, observations showed that some people spent their day with very little stimulation or interaction from staff, other than when being supported with their basic care needs. Quality assurance audits were in place to ensure the delivery of good quality care, however, not all systems and processes were audited. For example, the auditing of care plans did not take place and the registered manager had not recognised that a DoLS authorisation had expired. Records were not always consistently maintained and showed that the recording of moving and positioning as well as food and fluid charts had not always been completed in their entirety. Guidelines for staff to follow in relation to 'as and when required' medicines had been devised but not implemented and therefore staff were not provided with sufficient information to enable them to know when to administer 'as and when required' medicines and as a result people may not have had access to medicines when they needed them or they may have been administered inconsistently.

People were protected from harm and abuse. There were sufficient levels of appropriately skilled and

experienced staff who had undertaken the necessary training to enable them to recognise concerns and respond appropriately. People were able to take risks in accordance with risk assessments that had been devised and implemented. People told us that they felt safe. People received their medicines from registered nurses; they had these on time and according to their preferences. There were safe systems in place for the storage, administration and disposal of medicines. One person told us, "I get forgetful so they give my tablets to me". Another person told us, "They do it all. They do my blood sugar twice a day". Infection prevention and control was maintained, the environment was clean and people told us that they were happy with the cleanliness of the home. A comment within a recent quality assurance questionnaire stated, 'It is always clean, I appreciate that'. Another comment stated, 'The level of cleaning and hygiene maintained is exemplary'.

People were cared for by staff that were kind and caring, they were involved in their care and able to make their thoughts, preferences and concerns known. People's health needs were assessed and met by registered nurses who made referrals to external healthcare professionals when required. There were person-centred care plans in place that provided staff with information about people's needs, these were reviewed regularly and provided staff with guidance as to how to support people according to their preferences. People's privacy and dignity was respected and maintained, observations showed staff knocking on people's doors before entering. People had a positive dining experience and told us that they were happy with the quantity, quality and choice of food. One person told us, "It's pretty good and I'm quite fussy. The quality of the meat is very good. You can choose the food and if there is something you don't like or you fancy something that isn't on the menu, they'll do it for you".

People were supported to stay at the home until the end of their lives, there were suitable plans in place to ensure people could express their wishes and preferences with regard to their end of life care. A relative told us that they were happy with the care their loved one had received before they passed away, they told us, "The standard of care here has been superb, it has been brilliant as well as the support they have given us, the family".

The registered manager welcomed and encouraged feedback. People, relatives and staff were complimentary about the leadership and management of the home. The registered manager had developed an open culture and had an approachable nature. One person told us, "The management here is pretty good, you can talk to them and they come and see you". A relative told us, "I feel I can talk to the manager and nursing staff and they are positive and helpful".

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered manager to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The home was safe.

People received their medicines on time, these were dispensed by registered nurses and there were safe systems in place for the storage and disposal of medicines.

Sufficient numbers of staff ensured people's safety. Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

Risk assessments were in place to ensure people's safety. The home was clean and systems were in place to reduce the spread of infection.

Is the service effective?

Requires Improvement

The home was not consistently effective.

People were asked their consent before being supported. However, relevant people were not always involved in the decision making process when people lacked the capacity to give their consent. The registered manager was aware of the legislative requirements in relation to gaining consent for people who might lack capacity, however, this had not always been followed.

People were happy with the food provided. They were able to choose what they had to eat and drink and had a positive dining experience.

People were cared for by staff that had received training and had the skills to meet their needs. People had access to healthcare services to maintain their health and well-being.

Is the service caring?

Good

The home was caring.

People were supported by staff who were kind and caring and who knew their preferences and needs well.

Positive relationships had developed and there was a friendly and warm atmosphere.

People were treated with dignity and respect. They were able to make their feelings and needs known and able to make decisions about their care and treatment. This extended to people when they were at the end of their lives and people received good end of life care.

Is the service responsive?

Requires Improvement

The home was not consistently responsive.

Activities were provided to people on certain days, however, there was a lack of stimulation and interaction with people and some people were at risk of social isolation.

People received care that was in accordance with their needs and preferences and people were involved in their care.

There were mechanisms in place to enable people and their relatives to comment and complain about the care people received.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

Quality assurance processes monitored some systems and processes to ensure the delivery of high quality care and to drive improvement. However, not all systems were monitored and as a result actions that should have taken place were not carried out. Records were not consistently maintained.

People and staff were positive about the management and culture of the home.

People were treated as individuals, their opinions and wishes were taken into consideration in relation to the running of the home.

Manor Barn Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 29 November 2016 and was unannounced. The inspection team consisted of two inspectors. Before the inspection we asked the registered manager to complete a Provider Information Return (PIR). This is a form that asks the registered manager to give some key information about the home, what the home does well and improvements they planned to make. Prior to the inspection we looked at previous inspection reports and notifications that had been submitted. A notification is information about important events which the registered manager is required to tell us about by law. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with nine people, seven relatives, four members of staff and one visiting healthcare professional. We reviewed a range of records about people's care and how the service was managed. These included the care records for six people, medicine administration record (MAR) sheets, four staff training, support and employment records, quality assurance audits, incident reports and records relating to the management of the service. We spent time observing care and support in the communal lounge and dining room during the day. We also spent time observing the lunchtime experience people had and the administering of medicines.

The service was last inspected in April 2014 and no areas of concern were noted.

Good

Is the service safe?

Our findings

People told us that they felt safe and were able to call staff if they required assistance. When one relative was advised about the inspection, they told us, "It is nice to know that someone is keeping an eye on things but I don't think you have anything to worry about in this establishment".

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing identity and security checks had been completed and their employment history gained, as well as their suitability to work in the health and social care sector. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. Documentation confirmed that nurses had current registrations with the Nursing and Midwifery Council (NMC). A comment within a thank you card stated, 'Keep employing excellent staff. Everyone helped us even if it wasn't their particular task to do it'.

There were sufficient levels of staffing to meet people's needs. Due to the decrease in the number of people in the home, staffing levels had recently been reduced, however, the registered manager explained that these were flexible and would increase once more people resided in the home. The registered manager explained that they had experienced difficulties recruiting staff due to their close proximity to a local hospital. Staff told us that there were enough staff to meet people's needs but that they were busy and our observations confirmed this. When asked if there was enough staff one member of staff told us, "Sometimes barely, they keep leaving from time to time but this happens everywhere". People and relatives felt that there was sufficient staff on duty to meet people's needs and that when people required assistance staff responded in a timely manner and our observations confirmed this. One person told us, "They're pretty quick, sometimes you may have to wait a little while if they are helping other people but they are pretty good on the whole". Measures had been taken to ensure that people, who might physically be unable to use their call bell, had access to a means of calling for assistance. One person had been provided with an adapted bell so that they could press this if they required assistance, while others were provided with pendants that they could wear so that they could call for assistance wherever they were in the building. Records showed that regular checks had been made on people who were unable, due to their cognitive abilities, to use a call bell.

Staff had a good understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. One member of staff told us, "I'd tell a nurse, hand it over and tell the manager". There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. A whistleblowing policy provides staff with guidance as to how to report issues of concern that are occurring within their workplace.

Suitable measures had been taken to ensure that people were safe. Risk assessments recognised people's physical and clinical needs and were reviewed regularly. Staff confirmed that they found risk assessments and information within people's care plans useful as it provided them with guidance about how to support

people in a safe manner. Observations showed that staff were aware of risk assessments and worked in accordance with them. For example, care records for one person stated that the person needed to be supported by staff and that a stand-aid hoist should be used. Observations showed staff assisted the person to transfer from their armchair to a wheelchair using the recommended hoist.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular checks to ensure fire safety had been undertaken and people had personal emergency evacuation plans which informed staff of how to support people to evacuate the building in the event of a fire. Accidents and incidents were recorded and action had been taken to reduce the risk of the accident occurring again. For example, risk assessments and care plans had been updated to reflect changes in people's needs or support requirements.

People were protected by the prevention and control of infection. Staff had undertaken infection control training and infection control audits were carried out. There were safe systems in place to ensure that the environment was kept hygienically clean. Staff were observed undertaking safe infection control practices, they wore protective clothing and equipment, maintained hand hygiene and disposed of waste in appropriate clinical waste receptacles. A comment within a recent quality assurance questionnaire stated, 'It is always clean, I appreciate that'. Another comment stated, 'The level of cleaning and hygiene maintained is exemplary'.

People were assisted to take their medicines by registered nurses. Safe procedures were followed when medicines were being dispensed and administered and people's consent was gained before being supported. Observations showed one member of staff assisting a person to take their medicine on a spoon, as that was the person's preferred way of taking their medicines. People confirmed that if they were experiencing pain that staff would offer them pain relief and records confirmed that this had been provided. One person told us, "I get forgetful so they give my tablets to me". Another person told us, "They do it all. They do my blood sugar twice a day". Medicine records showed that each person had a medicine administration record (MAR) which contained information on their medicines. Records had been completed correctly and confirmed that medicines were administered appropriately and on time. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines.

Requires Improvement

Is the service effective?

Our findings

People were cared for by staff that had the relevant experience, knowledge and skills to meet their needs. People and relatives confirmed that they felt staff were competent, well trained and efficient. When asked about the experience and competence of staff, one person told us, "One or two of them haven't quite got their level two (diploma), but they get training here as well as the local hospice, but most are qualified before they come". A relative told us, "They seem to understand my relative's needs". However, despite these positive comments we found areas of practice that require improvement.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the registered manager was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. One person had a DoLS authorisation. DoLS authorisations have a date in which the DoLS expire and therefore registered managers are required to submit an application to renew the DoLS, to ensure that the person's condition remains unchanged and the original DoLS and any associated conditions still apply. However, records showed that the person's DoLS authorisation had expired four months previously. The registered manager had failed to recognise this and therefore the person was being deprived of their liberty unlawfully. Once this was brought to the registered manager's attention a DoLS application was made to the local authority.

The registered manger had undertaken mental capacity assessments for some people. Mental capacity assessments should be decision specific and assess a person's ability to understand the information related to the decision being made. The person should be able to retain and weigh up the information and communicate their decision. Records should show how the decision of capacity was reached. Records showed that these factors had been considered, however, some people had been assessed as having capacity but had not always been able to retain, weigh-up or communicate the decision and therefore may not have capacity to make certain decisions. Mental capacity assessments that had been completed were not decision specific and had been completed to assess a person's capacity for all aspects of their care.

Most people had physical disabilities and required support from staff to move around the home using mobility aids such as wheelchairs. Other people, due to their condition, spent their time in their beds. The registered manager explained that some people, due to their cognitive and physical abilities, would be unable to leave the home on their own and would require support from staff or be asked to return to the home if they were to leave unaccompanied. However, even though people were not asking to leave the home, they were still potentially being deprived of their liberty as they were not free to leave the home unaccompanied. The registered manager had not considered that some people might require DoLS authorisations. When this was raised with the registered manager they explained that they would seek

advice and guidance from the local authority with regard to this.

Records showed that some people had a lasting power of attorney appointed to act on their behalf. The registered manager had demonstrated good practice by ensuring that a copy of the documentation was kept. However, a lasting power of attorney can be for health and welfare or property and affairs. Records showed that some people, who had been appointed as lasting powers of attorneys, only had authorisation to act on people's behalf for their property and affairs and not their health and welfare. Records showed that these people had been consulted and asked to act on people's behalves in relation to their health and welfare. Therefore people, who were legally unable to make decisions on people's behalves, were asked to do so.

Observations identified that some people had bed rails in place. Under the Mental Capacity Act (MCA) 2005 Code of Practice, where people's movement is restricted, this could be seen as restraint. Bed rails can be implemented for people's safety but do restrict movement. Bed rails risk assessments were in place which considered the risk and how to eliminate the risk. However, for people who lacked capacity to consent to the use of bed rails, mental capacity assessments had not been completed in relation to their use and therefore some people's movement was being restricted unlawfully.

Care and treatment of people must only be provided with the consent of the relevant person. Decisions for some people had been made by someone who was legally unable to make those decisions and best interest decisions had not always involved the relevant people. DoLS authorisations had not been renewed and there was a potential lack of DoLS applications made. As a result people's movement was restricted unlawfully and without their consent. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff's learning and development was encouraged from the outset of their employment. New staff were supported to learn about the provider's policies and procedures as well as people's needs. An induction was completed to ensure that all new staff received a consistent and thorough induction. Staff had undertaken inductions and completed the care certificate. The care certificate is a set of standards that social care and health workers can work in accordance with. It is the minimum standard that can be covered as part of the induction training of new care workers. Staff were also able to shadow existing staff to enable them to become familiar with the home and people's needs, as well as to have an awareness of the expectations of their role.

Staff had completed training which the registered manager considered essential and this was updated regularly. In addition to this, training that was specific to the needs of people was also completed, such as supporting people living with dementia and those receiving end of life care. Registered nurses were also supported to keep their knowledge and skills up-to-date by undertaking the essential training and courses at the local hospice in addition to courses such as obtaining blood samples and catheterisation. There were links with external organisations to provide additional learning and development for staff, such as the local authority, the local hospice and private training providers. The registered manager had taken further measures to enhance staff's understanding about people's experiences. They told us that during staff handover meetings they had asked staff to assist each other to eat yoghurts, they had asked some staff to stand and support each other and others to sit and assist to gain an insight into people's experiences when they are being assisted with eating and drinking. Another task asked staff to hold straws in their mouths and only breathe through them when walking around the grounds of the home. The registered manager explained that this had helped staff to understand the difficulties that people might face when they have breathing problems. Staff told us that the training they had undertaken was useful and enabled them to understand people's needs and offer appropriate care. One member of staff told us, "You get to feel how the

residents feel". People were cared for by staff that had access to appropriate support and guidance within their roles. Regular supervision meetings took place to enable staff to discuss people's needs. These meetings provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us that they found supervisions helpful and supportive.

People's communication needs were assessed and met. People had access to relevant healthcare professionals to maintain or improve their communication, such as opticians and we observed people wearing the spectacles that had been provided. Some people had limited or no verbal communication, staff ensured that they took time to interpret people's needs and explained their actions when offering support. This was further confirmed by a relative who told us that staff always explained their actions and were able to interpret their relative's communication by observing their facial expressions. Effective communication also continued amongst the staff team. Regular handover and team meetings ensured that staff were provided with up to date information to enable them to carry out their roles. Observations of a handover meeting showed that staff were provided with information about each person's healthcare needs from staff that had worked during the previous shift.

People's health needs were met by registered nurses who made referrals to external healthcare professionals when required. These included GPs, speech and language therapists (SALT), dieticians, occupational therapists and physiotherapists. It was apparent that staff knew people well and staff told us that they were able to recognise any change in people's behaviour or condition if they were unwell to ensure they received appropriate support. People told us that staff ensured that they had access to medicines or healthcare professionals when they were not well. One person told us, "I have a doctor and they call them when I need to see them, I only need to see them once or twice a year".

People had a positive dining experience. Most people ate their meals in their rooms, with assistance from staff. However other people chose to eat their meal in the main dining area, some of whom were accompanied by their relatives. People had a choice of meals and were given a menu card to select their meals for the following day. People told us they were happy with the food available. One person told us, "It's pretty good and I'm quite fussy. The quality of the meat is very good. You can choose the food and if there is something you don't like or you fancy something that isn't on the menu, they'll do it for you". The dining room created a pleasant environment for people to have their meals, tables were laid with napkins, vases of flowers and condiments. People were able to choose where they sat and we observed people enjoying conversations with one another and with their visitors, who told us how important it was that they were able to stay and enjoy meals with their relatives.

Good

Is the service caring?

Our findings

People were supported by staff that were kind and caring and told us that they were happy living in the home. One person told us, "I wouldn't find a home that was much better".

There was a caring, friendly and relaxed atmosphere. Staff appeared to know people well and it was apparent that positive relationships had been developed. People told us that they liked staff. One person told us, "They're very good". Another person told us, "All the staff are really very nice". A relative told us, "Yes, they are kind and caring, it isn't an easy job". People were encouraged to maintain relationships with their family and friends. Observations showed people enjoying visits from family and friends, who told us that visiting was not restricted and that they were welcomed at any time. A relative told us, "We were able to have our diamond wedding party here, the hospitality was marvellous, and all our family were able to celebrate together".

People's differences were respected and staff adapted their approach to meet people's needs and preferences. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. Diversity was respected with regard to people's religion and people enjoyed visits from a local vicar if they chose to participate.

People were involved in decisions that affected their lives. Records showed that people and their relatives had been asked their preferences and wishes when they first moved into the home and that care plans had been reviewed in response to people's feedback or changes in their needs. People and relatives confirmed that they felt involved in the delivery of care to people and could approach staff if they had any questions or queries relating to it. Regular joint relatives' and residents' meetings were held enabling people to be kept informed of information relating to the running of the home, as well as being able to share their feelings and opinions. Records showed that within the meeting people had been reminded that they could approach the registered manager at any time and encouraged people and their relatives to discuss their comments and suggestions explaining that it enabled the management to improve the service.

People were asked their opinions and wishes and staff respected people's right to make decisions. Staff explained their actions before offering care and support and people felt that staff treated them with respect. The registered manager had recognised that people might need additional support to be involved in their care, they had involved people's relatives when appropriate and explained that if people required the assistance of an advocate then this would be arranged. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

People's privacy was respected and maintained. Information held about people was kept confidential, records were stored in locked cupboards and offices and handover meetings, where staff shared information about people, were held in private rooms to ensure confidentiality was maintained. People confirmed that they felt that staff respected their privacy and dignity. Staff were observed knocking on

people's doors before entering, to maintain people's privacy and dignity. When asked if staff maintained their privacy and treated them with dignity, one person told us, "Certainly, yes they do, they're very good at that. If I say I don't want to be disturbed they listen". A relative told us, "They always ask me to leave the room whilst they attend to my relative".

People were encouraged to be independent, as much as they were able to. Observations showed people independently eating and drinking and choosing how they spent their time. People told us that staff were there if they needed assistance but that they were encouraged and able to continue to do things for themselves and observations confirmed this.

People were able to stay at the home until the end of their life. People and relatives, if they were comfortable doing so, were asked their preferences in relation to their end of life care wishes. Records showed that people's end of life care had been discussed and advance care plans devised. These contained details of people's preferences with regard to spirituality, preferred place of care and who they wanted with them at the end of their lives. Anticipatory medicines had been prescribed and were stored at the home should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life. Staff had received training on end of life care and there were links with local hospices that provided practical support and advice to ensure that people received appropriate end of life care. A relative, who had experienced bereavement, told us, "The standard of care here has been superb, it has been brilliant as well as the support they have given us, the family".

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us that they were involved in decisions that affected people's care and that staff were responsive to their needs. However, despite this we found an area of practice that is in need of improvement.

The Social Care Institute for Excellence (SCIE) recommends that older people should be encouraged to construct daily routines to help improve or maintain their mental well-being and reduce the risk of social isolation. The provider employed an activities co-ordinator who worked on a part-time basis and who was working on the day of the inspection. There was an activities timetable that showed people had access to activities provided by external entertainers such as singers and magicians and playing games, quizzes and bingo on certain days. People told us that they enjoyed the entertainers. One person told us, "They have some things on that I often go to; in fact I'm going to one tomorrow. I'm lucky as I'm still quite able and have lots of things to get on with; the time seems to fly by. I'm sure some people, who aren't as able, don't have enough to do though". Our observations echoed this comment and showed that there was a lack of stimulation and meaningful activities for people who were less independent, for the duration of the inspection.

Observations showed people spending extended periods of time, alone in their rooms, or other areas of the home with minimal interaction from staff, other than to provide personal care or to provide food and drink. The Alzheimer's Society advises that people should take time to listen to people's feelings and show patience and understanding when supporting people who are experiencing signs of distress or anxiety. One person was displaying signs of apparent confusion and anxiety and was continually looking around for reassurance. Although staff did respond to the person, offering cups of tea and reassurances that it was nearly time for the person's meal, they did not take time to sit with the person to offer reassurance and support, and the person was left for extended periods of time with very little interaction or stimulation. When the person was asked about the staff, they told us, "They're nice but they are always so busy". Results of a recent quality assurance questionnaire contained a comment from a person that stated, 'I wish staff were not always in such a hurry, but otherwise they are good'. When asked if staff took time to spend with them, one person told us, "Not really". Records of a complaint that had been received stated, 'I know the staff are under a lot of pressure but in other care homes I have visited they frequently make an effort to spend at least some time talking with the residents. This may happen at Manor Barn but I don't think any of us have ever seen it'.

Records showed that assessments, to meet peoples' specific needs, had been completed. Several people spent their days in their rooms in their beds and as a result were at risk of social isolation. However, the registered manager had identified that this posed a risk to people and there were records in place to assess the risk of social isolation and to identify possible ways of reducing this risk. For example, records for one person advised staff to offer the person the opportunity to listen to music or watch television. It also advised staff to encourage the person to join in with the activities at the home and to sit in their wheelchair to enjoy time in the garden. People had televisions and radios in their rooms and the registered manager explained that staff would usually spend time with people and sometimes receive one to one support from staff,

however there was no evidence in people's daily records, that we were shown, to show that this had taken place. The lack of meaningful activities, interaction and one to one time with staff meant that there was a lack of stimulation for some people and some people were at increased risk of social isolation. These are areas of practice that are in need of improvement.

People's social, physical and health needs were assessed when they first moved into the home and care plans had been devised, these were person-centred, comprehensive and clearly documented the person's preferences, needs and abilities. Person-centred means putting the person at the centre of the planning for their lives. Records showed, and people and relatives confirmed, that they had been involved in the development and review of the care plans. One person told us, "They'll talk to you about your care". Another person and their relative told us that they had been invited to a meeting to discuss the person's care needs. A recent quality assurance questionnaire contained a comment that stated, 'We were fully informed of all aspects of our relative's care and changes in their condition'. There were regular reviews of people's care based on observations of their health and welfare and through feedback gained from people and relatives. These reviews took into consideration changes in people's needs and care was adapted accordingly.

People were supported to make choices in their everyday life. Observations showed staff respecting people's wishes with regard to what time they wanted to get up or go to bed, what clothes they wanted to wear, what they had to eat and drink and what they needed support with.

Assessments in relation to people's healthcare needs were completed. People's skin integrity and their risk of developing wounds were assessed using a Waterlow Scoring Tool, this took into consideration the person's build, their weight, skin type and areas of risk, age, continence and mobility. This assessment was used to identify which people were at risk of developing wounds. None of the people had pressure related wounds, however, for people who had other wounds, wound assessment charts had been completed providing details of the wound and the treatment plan recommended. There were mechanisms in place to ensure that people at risk of developing pressure wounds had appropriate equipment to relieve pressure to their skin, these included specialist cushions and air mattresses. People had been assessed to determine the type of cushion and mattress that was appropriate as well as the setting that the mattress was required to be on. Records showed that checks to ensure that settings for mattresses were correct had been carried out and were further confirmed by our observations. People's risk of malnutrition was assessed upon admission, a Malnutrition Universal Screening Tool (MUST) was used to identify people who were at a significant risk and they were weighed each month to ensure that they were not losing any more weight. Records showed that referrals to health professionals had been made for people who were at risk of malnutrition and nutritional supplements were provided and food fortified to increase people's calorie intake.

There was a complaints policy in place, complaints that had been made had been dealt with appropriately and in accordance with the provider's policy. The registered manager encouraged and welcomed feedback from people and their relatives. Regular meetings as well as annual surveys were sent to gain people's feedback and leaflets advising people of a website that they could access to make their compliments or concerns known were displayed. People told us that they knew how to make a complaint but were happy with their care and didn't feel the need to complain. One person told us, "I've got no objections or complaints".

Requires Improvement

Is the service well-led?

Our findings

People, relatives, staff and a visiting healthcare professional were complimentary about the leadership and management of the home. They told us that the registered manager was supportive and approachable. One person told us, "The management here is pretty good, you can talk to them and they come and see you". A relative told us, "I feel I can talk to the manager and nursing staff and they are positive and helpful". A member of staff told us, "The management, seniors and nurses are all approachable". However, despite these positive comments, we found areas of practice in need of improvement.

There were some good systems in place to ensure that the home was able to operate effectively and to ensure that the practices of staff were meeting people's needs. There were quality assurance processes such as surveys that were sent to gain feedback as well as regular audits conducted, including medication and infection control, which provided the registered manager with an oversight and awareness of the home to ensure that people were receiving the quality of service they had a right to expect. However an audit on the care plans did not take place and therefore the registered manager had not recognised that a DoLS authorisation had expired and that a person was being deprived of their liberty unlawfully.

Records, in relation to people's care and treatment, were not always consistently maintained. For example, daily records documenting people's moving and positioning or food and fluid intake had not always been consistently maintained. The registered manager had recognised this in the past and had addressed this with staff at a staff meeting, however observations showed that inconsistencies within records was still an area that needed to be improved. There were no records or risk assessments in relation to another potential area of risk within the home. For example, the home has a staff flat. Access to the flat was gained by walking through the home through either the main entrance or the back door to the home. When asked if potential risks had been assessed such as, ensuring that the providers' insurance and the local authority who placed people in the home were aware and that visitors to the flat were appropriately checked or supervised to ensure they could have access to vulnerable people, the registered manager explained that these had not been considered.

Records in relation to the administration of certain medicines were not always in place. People had been prescribed medicines that they could take as and when they required them. The National Institute for Health and Care Excellence (NICE) quality standards 'Managing Medicines in Care Homes' recommends that care homes should ensure that a process for administering 'when required' medicines is included in the care homes medicines policy. It states that policies should include clear reasons for giving 'when required' medicine, minimum time between doses if the first dose has not worked, what the medicine is expected to do, how much to give if a variable dose is prescribed, offering the medicines when needed and not just during 'medication rounds' and recording 'when required' medicines in people's care plans. Although the registered manager had devised a medicines policy that addressed these issues, this had not been implemented and therefore there were no guidelines that related to individual people, for staff to follow in relation to 'as and when required' medicines. This was raised with the registered manager and staff who explained that they knew people well and were able to ask them if they required any 'as and when required' medicines or would discuss as a staff team and make a decision. However, one person who was prescribed

'as and when required' medicines was unable to indicate to staff when they might require these medicines. Staff told us that they would be able to notice if there were changes in the person's condition and discuss this as a team and a decision would be made as to whether the person required their 'as and when required' medicines. Staff were not provided with clear guidance to follow in relation to 'as and when required' medicines. This meant that people may not have had access to medicines when they needed them or that they may have been administered in an inconsistent way.

There was a lack of effective quality monitoring systems as well as a lack of maintenance of records relating to the care and treatment of people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team consisted of a registered manager and a deputy manager. There was a warm, homely and relaxed atmosphere and people told us that they were comfortable and felt at home. A relative told us, "It feels like a home. We looked at a lot of other care homes and we chose this one because it felt so homely". One person told us, "You won't find a better home anywhere. They're brilliant, absolutely delightful". When asked what their vision for the home was, the registered manager told us, "I've been here for a long time, we look after the residents and we consider them as family. I've got nice members of staff and we are providing very good care". This was implemented in practice and it was apparent that the staff shared a similar vision too.

The registered manager ensured that there were links with external organisations and professionals to ensure that the staff were providing the most effective and appropriate care for people and that staff were able to learn from other sources of expertise. The providers attended regular meetings with other registered managers and providers within the area to share best practice. The registered manager worked closely with external health care professionals to ensure that people's needs were met and that the staff team were following best practice guidance. They were aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11(1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent. The registered person had not ensured that suitable arrangements were in place for obtaining and acting in accordance with the consent of service users or establishing and acting in accordance with the best interests of the service user in line with Section 4 of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. The registered person had not assessed, monitored or improved the quality of the service and had not maintained secure, accurate, complete and contemporaneous records in respect of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.